PATIENT INFORMATION (please print)

Name____ Birthdate ___/___/___ Age_____

Home Phone (_____) _____________ Cell Phone (____) _________________ Email_____________________________

Which Phone Number would you like for us to use to confirm appointments? (Circle) Home Work Cell

Social Security Number ____-____-_____ Street Address (required) ____

City______________________________ State ________ Zip ____________

Circle Appropriate: Minor Single Married Divorced Widowed Separated

Patient's Employer ____ Work Phone (_____)_____________

Business Address____________________________________City___________________State_______Zip __________

If over 18 years old - Are you a full-time student? YES NO Where? _____________________________________

Spouse's Name____________________________________ Employer ____

Work Phone (_____) ______________ Cell Phone (_____) ______________ Email ______________________________

Person to Contact In the Case of an Emergency ________________________________ Phone (_____) ______________

Whom May We Thank For Referring You____

IF PATIENT IS A MINOR, PLEASE GIVE RESPONSIBLE PERSON'S INFORMATION

Name of Person Responsible for This Account___________________________________Relationship______________

Is the Responsible Party Currently a Patient in our Office: YES NO (If no, then continue to next line?)

Address____________________________________City_______________________State _________Zip____________

Social Security Number____-____-_____ Home Phone Number (_____) __________Work Phone (_____) ________

Cell Phone (____) ____________ Email ____

Employer_____________________________ Employer Address ____

PLEASE READ AND SIGN BELOW IF YOU HAVE DENTAL INSURANCE!!

I authorize the release of any information relating to my dental claim ____

I authorize my insurance to pay Richard T. Carlyle, DDS directly ____